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	155775	A. BUILDING 01 B. WING	05/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND POINTE HEALTH CAMPUS	1051 CUMBERLAND AVE WEST LAFAYETTE, IN47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/16/11 Facility Number: 000547 Provider Number: 155775 AIM Number: 100267440 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Cumberland Pointe Health Campus was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility was located on the east wing of a one story fully sprinklered building determined to	K0000	Survey Event ID: ZC0621 The submission of this POC does not indicate an admission by Cumberland Pointe Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Cumberland Pointe Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	be of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 143 and had a census of 117 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0011 SS=E	If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 Based on observation and interview, the facility failed to ensure 1 of 1 doors in the fire barrier separating health care from the assisted living occupancy provided the protection needed for a two hour fire barrier. LSC 19.1.1.4.2 refers to LSC 8.2. LSC 8.2.3.2.3.1 requires openings in a	K0011	CORRECTIVE ACTIONThis fire door separating health care from assisted living occupancy was installed as part of the addition of the assisted living in 1997 and did pass LSC inspection and meet LSC code requirements. A quote is being obtained for purchase of and installation of fire doors with a one and one-half hour designated rating in the two hour fire barrier. Due to the length of	08/01/2011

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	2 hour fire barrier be provided with doors having at least a 1 1/2 hour fire protection rating. This deficient practice could affect visitors, staff and 44 residents of the comprehensive care unit. Findings include: Based on observation with the maintenance director on 05/16/11 at 12:25 p.m., the door installed in a two hour fire separation wall between the health care center and assisted living quarters had a one hour fire rating, less than the one and one half hour rating required for a door in a two hour fire wall. The maintenance director said at the time of observation, he was unaware of fire rating requirements. 3.1-19(b)		time for delivery of the fire doors from the manufacturer that is anticipated to be 6-8 weeks, the campus is requesting an extension of 60 days for the completion date. Staff will be educated during the 60 day period that the two hour fire barrier will only provide one hour of protection and residents will be moved to another compartment with approved fire doors in the two hour fire barrier during a fire alarm where compartment evacuation would be needed. IDENTIFY OTHER RESIDENTSAll residents affected were identified in the finding. No other residents would be impacted. MEASURES/SYSTEMIC CHANGESThe Plant Operations Director will be in-serviced regarding the fire rating requirements for doors in a two hour fire separation wall. All doors in two hour fire separation walls in the campus have been inspected to ensure the fire ratings on the doors are in compliance with the doors being rated with a one and one-half hour rating. A monthly preventative maintenance check will be conducted to ensure that all doors in the two hour fire separation walls continue to have the proper rating noted on the doors. MONITORING CORRECTIVE ACTIONThe monthly preventative maintenance check audit results will be reported to the QA	

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			committee for three months. If any negative trends are noted in the audit results, the QA committee will recommend changes in the interventions and extend the monthly review an additional three months to ensure effectiveness of the new interventions.	
K0021 SS=E	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 1. Based on observation and interview the facility failed to ensure access doors to 4 of 12 hazardous areas were held open only with a device which allowed the door to close automatically. This deficient practice could affect visitors, staff and 77 residents on Pine unit. Findings include: Based on observation with the maintenance director on 05/16/11	K0021	CORRECTIVE ACTION1. Door to the medical supply storage rooms near 208 and 308, to room 330 and the activities storage room near 316 are being repaired to ensure the doors self-close. 2. The self-closure device on the double doors to the kitchen is being replaced to ensure the doors self-close and latch. A quote is been obtained for purchase of and installation of a new self-closure device. Due to the length of time for delivery and installation of the self-closure device that is anticipated to be 4-6 weeks, the campus is requesting an extension of 45	07/15/2011

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	between 10:15 a.m. and 2:20 p.m., self closing doors in the following areas failed to self close: a. To the medical supply storage rooms near 208 and 308 when they hit the door frame; b. To room 330 when the door hit the unlevel carpeted floor; c. To the activities storage room near 316, when the door hit the door frame. The maintenance director said at the time of the observations, the doors would require repair. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 12 doors to a hazardous area would self close. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects 4 staff in		days for the completion date. Staff will be educated during the 45 day period that the double kitchen doors to the service corridor may not latch properly and kitchen staff will be required to close and latch the kitchen doors as they exit the kitchen in a fire alarm. IDENTIFY OTHER RESIDENTSAll residents affected were identified in the finding. No other residents would be impacted. MEASURES/SYSTEMIC CHANGESThe Plant Operations Director will be in-serviced regarding the requirements for self-closing devices and proper function of the self-closing devices on doors to hazardous areas. A monthly preventative maintenance inspection will be conducted on all doors to hazardous areas to ensure the self-closing devices on those doors allow the doors to close automatically upon activation of the fire alarm system and latch properly. MONITORING CORRECTIVE ACTIONThe monthly preventative maintenance check audit results will be reported to the QA committee for three months. If any negative trends are noted in the audit results, the QA committee will recommend changes in the interventions and extend the monthly review an additional three months to ensure effectiveness of the new interventions.	

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	the kitchen. Findings include: Based on observation with the maintenance director on 05/16/11 at 1:10 p.m., self closing double doors to the kitchen from the service corridor failed to self close and latch due to the malfunction of the self closing devices. The maintenance director said at the time of observation, he didn't know about the door closing requirements. 3.1-19(b)			
K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure openings through ceiling	K0025	CORRECTIVE ACTIONa. The foam in the eight conduit penetrations in the boiler and generator transfer switch room	06/15/2011

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	and wall smoke barriers in 3 of 6 smoke compartments were protected with approved materials to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and 20 or more residents in Wing 2, 3, 6, 9 and the main lounge. Findings include: Based on observation with the maintenance director on 05/16/11 between 10:15 a.m. and 2:20 p.m., the following was observed: a. Openings around eight conduit penetrations in the boiler and generator transfer switch room ceiling and wall were filled with expandable foam; b. The opening around the sprinkler pipe in the ceiling in the		ceiling and wall openings is being removed and the penetration filled with a fire rated caulk. b. The foam in the opening of the sprinkler pipe in the ceiling in the freezer is being removed and the penetration filled with a fire rated caulk. c The opening in the ceiling around a waterline penetration in the kitchen adjacent to the range hood is being sealed with a fire rated caulk. IDENTIFY OTHER RESIDENTSAll residents affected were identified in the finding. No other residents would be impacted. MEASURES/SYSTEMIC CHANGESThe Plant Operations Director will be in-serviced regarding the requirements for properly protecting ceiling and wall penetrations with an approved material capable of maintaining the smoke resistance of the smoke barrier. All Plant Operations staff will be in-serviced regarding the need to ensure any new penetrations in a smoke barrier must be filled with a fire rated caulk. An audit form is being created to document the monthly inspection of smoke barriers to ensure no open penetrations are observed and that all penetrations are filled with a fire rated caulk. MONITORING CORRECTIVE ACTIONThe monthly audit results will be reported to the QA committee for three months. If any negative trends are noted in the audit	

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	freezer was filled with an expandable foam; c. The opening in the ceiling around a waterline penetration in the kitchen adjacent to the range hood was unsealed leaving a 1/2 inch annular gap. The maintenance director said at the time of observations, he was unaware of requirements for protecting ceiling and wall penetrations. 3.1-19(b)		results, the QA committee will recommend changes in the interventions and extend the monthly review an additional three months to ensure effectiveness of the new interventions.	
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to provide automatic closing devices on hazardous room doors in 2 of 8 smoke compartments. This	K0029	CORRECTIVE ACTIONAutomatic self-closing devices are being added to the medical records/supply storage room near 308 and to the comprehensive shower room used for collection	07/15/2011

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	deficient practice affects visitors, staff and 77 residents on the pine unit. Findings include: Based on observations on 05/16/11 between 10:15 a.m. and 2:15 p.m., the medical records/ supply storage room near 308 and the comprehensive shower room used for the collection of soiled linen and trash carts each had doors which were not equipped with self closing devices. The maintenance director said at the time of observation, he was not aware the rooms required self closing doors. 3.1-19(b)		of soiled linen and trash carts. A quote is been obtained for purchase of and installation of these new self-closure devices. Due to the length of time for delivery and installation of the self-closure devices that is anticipated to be 4-6 weeks, the campus is requesting an extension of 45 days for the completion date. Staff will be educated during the 45 day period that the doors to the medical records/supply storage room near 308 and the comprehensive shower room used for collection of soiled linen and trash carts will not close automatically and staff will be required to close and latch the doors if open when a fire alarm sonds. IDENTIFY OTHER RESIDENTSAll residents affected were identified in the finding. No other residents would be impacted.MEASURES/SYSTEMIC CHANGESThe Plant Operations Director will be in-serviced regarding the requirements for self-closing devices and proper function of the self-closing devices on doors to hazardous areas. A monthly preventative maintenance inspection will be conducted on all doors to hazardous areas to ensure the self-closing devices on those doors allow the doors to close automatically upon activation of the fire alarm system and latch properly. MONITORING CORRECTIVE ACTIONThe	

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			monthly preventative maintenance check audit results will be reported to the QA committee for three months. If any negative trends are noted in the audit results, the QA committee will recommend changes in the interventions and extend the monthly review an additional three months to ensure effectiveness of the new interventions.	
K0048 SS=E	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on observation, record review and interview; the facility failed to develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 40 of 117 residents. This deficient practice could affect 40 residents. Findings include: Based on observations with the maintenance director between 10:15 a.m. and 11:00 a.m. on 05/16/11, individual smoke detectors were located in resident rooms 101 to 120. Based on review of the facility's Fire Procedures with the maintenance director on 05/16/11 at 11:30	K0048	CORRECTIVE ACTIONFire procedures for the campus do require staff to activate the nearest pull station if they observe smoke or fire and the fire alarm is not sounding. The policy is being revised to clearly state that if a staff member hears a battery powered smoke detector sounding they are to immediately respond to the room and if smoke or fire is observed to remove the resident(s) and activate the nearest pull station. If smoke or fire is not observed the staff are to immediately contact Plant Operations to inspect the smoke detector. IDENTIFY OTHER RESIDENTSAll residents affected were identified in the finding. No other residents would be impacted. MEASURES/SYSTEMIC CHANGESStaff members from all departments will be in-serviced on the revised fire procedures. An audit will be conducted monthly of all battery	06/15/2011

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	a.m., there was no procedure for a specific response to a battery powered smoke detector alarm. The maintenance director said at the time of record review, he knew of no policy for a special response to activation of battery powered smoke detectors. 3.1-19(b)		powered smoke detectors to ensure the units are functioning properly. MONITORING CORRECTIVE ACTIONThe audit results of the monthly checks of battery powered smoke detectors will be reported to the QA committee for three months. If any negative trends are noted in the audit results, the QA committee will recommend changes in the interventions and extend the monthly review an additional three months to ensure effectiveness of the new interventions.	
K0056 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 1. Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 1 exterior emergency exits covered by a combustible canopy attached to the building. NFPA	K0056	CORRECTIVE ACTION1. The sunshade lattice canopy outside the Comprehensive dining room is not attached to the building. It is leaning towards the building and bracing will be installed on the lattice to restore the lattice to it's proper vertical position. 2.	06/15/2011

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	13, 1999 Edition at 5-13.8.1 requires sprinklers be installed under combustible exterior roofs or canopies exceeding four feet in width. This deficient practice affects residents, staff, and at at least 20 residents using the comprehensive care dining room. Findings include: Based on observation with the maintenance director on 05/16/11 at 12:15 p.m., a twelve by eight foot wooden lattice sunshade canopy was attached to the building outside the comprehensive care dining room. The covered area included the emergency exit from the dining room. The maintenance director agreed at the time of observation, the construction material was combustible. The area was not protected by sprinklers. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the minimum distance between sprinklers in 1 of 8 resident use areas. NFPA 13,		Upon follow-up inspection there are not three pendant ceiling sprinkler heads spaced five feet apart in the Pines assisted dining room. All sprinkler heads in the Pines assisted dining room are spaced properly. IDENTIFY OTHER RESIDENTSAll residents affected were identified in the finding. No other residents would be impacted. MEASURES/SYSTEMIC CHANGESThe sunshade lattice canopy will be inspected monthly during grounds inspection to ensure it is remaining braced properly away from the building. MONITORING CORRECTIVE ACTIONThe grounds inspection reports will be submitted to the QA committee for three months to ensure the bracing is properly keeping the lattice canopy from contact with the building. Should any negative trends be noted, additional bracing or adjustment to the lattice canopy will be implemented and the grounds inspection reports will be monitored for an additional three months to ensure compliance.	

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	1999 Edition at 4-7.3.4 requires sprinklers shall be spaced not less than 6 feet on center. This deficient practice affects staff, visitors and 12 residents on the Pine unit. Findings include: Based on observation with the maintenance director on 05/16/11 at 1:00 p.m., three pendant ceiling sprinkler heads were spaced five feet from one another in the Pines unit assisted dining room. The maintenance director agreed at the time of observation, the sprinkler heads were not at the minimum distance of six feet apart. 3.1-19(b)			
K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to ensure a supply of spare sprinkler heads included at least two of each type of sprinkler head	K0062	CORRECTIVE ACTION1. Spare sprinkler heads have been ordered to be on hand to ensure the minimum replacement heads are available in the building for each type of sprinkler head. 2.	06/15/2011

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	155775	A. BUILDING 01 B. WING	05/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	installed in the facility for 1 of 1 automatic sprinkler systems. NFPA 25, 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect 77 residents in the Pines unit. Findings include: Based on observation with the maintenance director on 05/16/11 at 1:55 p.m., spare sprinkler heads were located in the boiler room. The supply did not include a standard release sprinkler head which were observed in the resident rooms and common areas on the Pines unit. The maintenance director said at the time of observation, he did not have any other spare sprinkler heads and could not say at the time of discovery, if the heads on		The installation of the sprinkler heads in the comprehensive care unit medicine storage room and the medical records/storage area near 308 have been corrected so sprinkler heads are properly installed. A new sprinkler head was ordered and will be installed for the Pines utility room. 3. A new sprinkler head has been ordered for the Kitchen freezer and will be installed as soon as delivered. IDENTIFY OTHER RESIDENTSAll sprinkler heads in the entire building have been inspected and no other sprinkler heads were found with improper installation. No other residents would be affected. MEASURES/SYSTEMIC CHANGESA monthly audit of spare sprinkler heads will be completed to ensure at least two of each type of sprinkler are stored in a cabinet on the premises for replacement purposes. Each quarter inspection of all sprinkler heads will be completed to ensure they are clean, properly installed, and in reliable operating condition.MONITORING CORRECTIVE ACTIONThe monthly audit of spare sprinklers and the quarterly inspection of sprinkler heads will be reported to the QA committee for three months. If any negative trends are noted in the audit results, the QA committee will recommend changes in the interventions and extend the	

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	155775	A. BUILDING 01 B. WING	05/16/2011

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	hand represented all other types of sprinklers installed in the facility. 3.1-19(b) 2. Based on observation, the facility failed to ensure sprinkler heads providing protection for 2 of 6 smoke compartments were maintained. This deficient practice could affect any staff, visitors and residents in the vicinity of the three rooms involved. Findings include: Based on observations during a tour of the facility with the maintenance director on 05/16/11 between 10:15 p.m. and 2:15 p.m., sprinkler head escutcheons were missing, improperly installed, or displaced, leaving a gaps of 1/4 to 1/2 inch into the attic above in the soiled utility room on the Pines unit, the medicine room on the comprehensive unit and the medical records/storage room near 308.		monthly review an additional three months to ensure effectiveness of the new interventions.	

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	3.1-19(b) 3. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 6 service areas was free of foreign materials, such as grime. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects 4 kitchen staff. Findings include: Based on observation with the maintenance director on 05/16/11 at 1:05 p.m., the kitchen freezer sprinkler head was covered with a thick grey grime. The maintenance director agreed at the time of observation, the sprinkler head was not in good operating condition. 3.1-19(b)			
K0069 SS=D	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to	K0069	CORRECTIVE ACTIONThe kitchen floor will be marked to identify the proper placement of	06/15/2011

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	ensure 1 of 1 commercial cooking extinguishing systems was maintained. NFPA 96, 7-2.2 requires automatic fire extinguishing systems shall comply with Standard UL 300, Fire Testing of Fire Extinguishing Systems for Protection of Restaurant Cooking Areas. This deficient practice could affect 4 kitchen staff. Findings include: Based on observation of the commercial kitchen range hood protection system with the maintenance director on 05/16/11 at 1:00 p.m., protection was not provided for eight inches of the fryer which was not positioned under the hood. The maintenance director said at the time of observation, he did not know anything about the hood protection requirements. 3.1-19(b)		the fryer to ensure it is fully covered by the hood protection system. IDENTIFY OTHER RESIDENTSAll residents affected were identified in the finding. No other residents would be impacted. MEASURES/SYSTEMIC CHANGESThe Plant Operations Director will be in-serviced regarding the hood protection requirements for the kitchen.Dining services cooking staff will be in-serviced regarding the importance of ensuring the fryer is properly positioned under the hood at all times. An audit will be completed weekly to ensure all kitchen cooking equipment is properly positioned under the hood protection system. MONITORING CORRECTIVE ACTIONThe weekly audit results will be reported to the QA committee for three months. If any negative trends are noted in the audit results, the QA committee will recommend changes in the interventions and extend the monthly review an additional three months to ensure effectiveness of the new interventions.	

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K0076 SS=E	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure oxygen stored in 1 of 1 sprinklered oxygen storage areas was properly separated from combustibles. NFPA 99, Health Standards for Health Care Facilities, and NFPA 99, 8-3.1.11.2(c) requires the minimal separations from oxygen and combustibles in a sprinklered building be 5 feet or an enclosed cabinet of noncombustible construction having a minimum fire protection rating of one half hour for cylinder storage. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. This deficient practice affects staff, visitors and 77 residents on the Pine unit. Findings include:	K0076	CORRECTIVE ACTIONAll combustible plastic, paper and cardboard wrapped supplies have been removed from the oxygen storage room. IDENTIFY OTHER RESIDENTSAll residents affected were identified in the finding. No other residents would be impacted. MEASURES/SYSTEMIC CHANGESThe Plant Operations Director will be in-serviced regarding the oxygen storage requirements to ensure proper separation from combustibles. Staff from all departments will be in-serviced regarding the requirements to keep all combustible items out of the oxygen storage area. An audit will be completed weekly of the oxygen storage room to ensure that the space meets requirements of no combustibles in the space. MONITORING CORRECTIVE ACTIONThe weekly audit results will be reported to the QA committee for three months. If any negative trends are noted in the audit results, the QA committee will	06/15/2011

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	Based on observation with the maintenance director on 05/16/11 at 12:40 p.m., the oxygen supply storage room was used for the storage of plastic, paper and cardboard wrapped supplies located immediately adjacent to liquid oxygen containers stored in the room. The maintenance director said at the time of observation, he was unaware of the separation requirement. 3.1-19(b)		recommend changes in the interventions and extend the monthly review an additional three months to ensure effectiveness of the new interventions.	
K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfer	K0143	CORRECTIVE ACTIONSignage has been ordered and will be installed for the oxygen room that clearly indicates it is oxygen	06/15/2011

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	sites was posted with a sign indicating oxygen transferring was taking place, provided with continuous mechanical ventilation to the outside and separated from any portion of the facility wherein residents are housed by a fire barrier of 1 hour fire resistive construction. This deficient practice affects staff, visitors and 77 residents on the Pine unit. Findings include: Based on observation with the maintenance director on 05/16/11 at 12:40 p.m., seven liquid oxygen supply containers and nine small oxygen cylinders were stored in a room on the Pines unit. LPN #1 interviewed at the time of observation said the room was used for the transfilling of portable oxygen tanks. There was no sign to identify the room, it's contents, and to provide notice it was used for oxygen transfer. There was no fire rating on the door. When asked at the time of observation, the maintenance director said he did not know if the mechanical ventilation provided exhausted directly to the		storage and will allow staff to note that oxygen transfilling is taking place. The door to the oxygen room is being replaced with a door that will be clearly labeled to meet the fire rating requirements. The oxygen room is currently mechanically vented to the outside for continuous mechanical ventilation. IDENTIFY OTHER RESIDENTSAll residents affected were identified in the finding. No other residents would be impacted.MEASURES/SYSTEMIC CHANGESNursing staff will be in-serviced on the importance of properly using the signage on the oxygen door to indicate when transfilling is taking place. Random audits will be conducted monthly by nursing managers to ensure staff are properly using signage when transfilling. A monthly preventative maintenance check will be conducted to ensure that the door to the oxygen storage room continues to have the proper rating noted on the door. MONITORING CORRECTIVE ACTIONThe monthly audit results will be reported to the QA committee for three months. If any negative trends are noted in the audit results, the QA committee will recommend changes in the interventions and extend the monthly review an additional three months to ensure effectiveness of the new interventions.	

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	outside. 3.1-19(b)			
K0144 SS=C	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c)	K0144	CORRECTIVE ACTIONA quote has been obtained and a remote manual stop station is being installed on the generator for emergency shut-off. IDENTIFY OTHER RESIDENTSAll residents affected were identified in the finding. No other residents would be impacted. MEASURES/SYSTEMIC CHANGESThe proper functioning of the remote manual stop station on the generator will be checked monthly during generator testing. MONITORING CORRECTIVE ACTIONThe monthly testing results will be reported to the QA committee for three months. If during any testing of the remote manual stop station there are problems identified with functioning, the generator maintenance contract company will be contacted immediately for repair to ensure proper functioning.	06/15/2011

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	requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on interview during record review on 05/16/11 at 11:20 a.m. with the maintenance director, the upgraded emergency generator was installed after 2003. The maintenance director also said at the time of record review, he didn't know if there was a remote emergency shut off for the emergency generator. Upon inspection of the generator and it's components on 05/16/11 at 2:00 p.m., no remote emergency shut off for the generator was found. A call placed to the generator contractor on 05/16/11 at 2:10 p.m. by the maintenance director confirmed no such device had been installed. 3.1-19(b)			

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K0147 SS=E	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring in 2 of 8 smoke compartments. NFPA 70 (National Electrical Code), 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 52 residents in the comprehensive unit and 200 hall smoke compartment. Findings include: Based on observation with the maintenance director on 05/16/11 between 10:15 a.m. and 2:20 p.m., the following was observed: 1. A power strip extension cord provided power to an aquarium in the area across from the comprehensive unit nurse station; 2. A power strip extension cord was piggy backed to an extension	K0147	CORRECTIVE ACTION1. A receptacle is being installed in the comprehensive care unit for the aquarium to be plugged into. 2. Extension cords have been removed from the activities room. 3. Extension cords have been removed from room 221 and the bed has been plugged into the wall receptacle properly. IDENTIFY OTHER RESIDENTSAll residents affected were identified in the finding. No other residents would be impacted.MEASURES/SYSTEMIC CHANGESStaff in all departments will be in-serviced regarding the requirements for no extension cords and that flexible cords cannot be used as a substitute for fixed wiring. An audit will be completed monthly to inspect resident rooms, offices and common areas to ensure items are plugged into receptacles appropriately. MONITORING CORRECTIVE ACTIONThe monthly audit results will be reported to the QA committee for three months. If any negative trends are noted in the audit results, the QA committee will recommend changes in the interventions and extend the monthly review an additional three months to ensure	06/15/2011

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	cord in the activities room; 3. Two extension cords were in use on the resident bed side of the room to power lighting and a lift chair in room 221. The maintenance director said at the time of observations, he was unaware of restrictions for the use of power strips and extension cords. 3.1-19(b)		effectiveness of the new interventions.	